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May 25, 2011

Kevin Morrill, Chief
Office of Medi-Cal Procurement
State of California
Health and Human Services Agency
Department of Health Care Services
P.O. Box 997413
Sacramento CA 95899-7413

Dear Mr. Morrill,

Thank you for the opportunity to reply to your Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare.

Please find below our brief responses to your questions from the perspective of a small behavioral health agency contracted with two county Departments of Mental Health under the Rehabilitation Option. Our service population in Los Angeles County is over 80% dually eligible; our population in San Diego County is 72% dually eligible.

Please feel free to contact me if I may provide any further information or support and I would also be interested in participating in your technical advisory panel, as I participated in the Dual Eligible Technical Workgroup. My direct contact information is ckelartinian@cfar1.org or 626-577-8480, extension 115.

Sincerely,

Cynthia Jackson Kelartinian, Ph.D.
Executive Director, Heritage Clinic
Heritage Clinic and the Community Assistance Program for Seniors

Questions and Answers for Dual Eligible Request for Information

1. What is the best enrollment model for this program?

Enroll persons through any Medicare or Medi-Cal funded gatekeeper, including primary care medical offices, health plans, behavioral health plans, hospitals, managed care networks, Medi-Cal waiver programs, that is, any program or fee-for-service provider funded by Medi-Cal or Medicare. Utilize a single assessment tool for intake (e.g., the MSSP assessment form). Any of these gatekeepers would provide information to dually eligible patients. Similarly, any of these gatekeepers could link his or her beneficiaries with a care coordinator who would complete the enrollment.

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

(not necessarily comprehensive nor in order by preference)

IHSS
Adult Day Health Care
Adult Day-Care Resource Centers
Behavioral health outpatient, inpatient and field based services
Clinical assessment regarding questions of diminished capacity
Supportive Housing Services including board and care facilities, assisted Living facilities and skilled nursing facilities
Primary Care
Home based medical care
In-home dementia care
Money management
Benefit establishment
Conservators, including Office of Public Guardian
Substance abuse services
Community Health Worker (*promotora*) Model of service delivery
Current home and community based Medi-Cal waiver programs such as MSSP and the assisted living waiver

3. How should behavioral health services be included in the integrated model?

Behavioral health services should be incorporated into the spectrum of integrated services. They should be co-located, whether in clinics or field based, and delivered as a primary care service. Behavioral health screenings should be included in medical primary care. Illness self-management approaches should be applied to mental illness and substance abuse.

Behavioral health care should be provided at the first point of entry into the system, in conjunction with medical services, including assessment and treatment of mental illness as a primary illness. Behavioral health services should also be included as secondary, long-term care. Behavioral health services need to be applied to persons with complicated mental illnesses, as well as more mild mental illnesses. In describing behavioral health, we are including substance-abuse and dementia-care services.

Services should be related to medical necessity and functional impairment as measured by standard and observable measures.

All services should coordinated by a single person with whom the patient has a relationship. If the patient has high behavioral health needs, the care coordinator should have behavioral health expertise. While behavioral health care only currently accounts for a minimal amount of expenditures in this population, in our experience, the benefits are substantive.

4. If you are a provider of long-term supports and services, how would you propose participating in an integration pilot? What aspects of your current contract and reimbursement arrangement would you want to keep intact, and what could be altered in order to serve as a subcontractor for the contracted entities?

We would provide both short- and long-term behavioral health care interventions at a primary care level for screening and short-term, and ongoing as needed. We would provide services in the community, in the outpatient behavioral health setting and in the primary care medical setting. We would provide the full array of Rehabilitation Option behavioral health services.

Our preferred choice would be to continue to provide services through a contract with county Departments of Mental Health, similar to the current Rehabilitation Option, but with blended funding. However, another acceptable option would be to provide services at a flat fee-for-service rate. Another workable option would be to provide services at a capitated rate with profit sharing. The capitated rate would be set by psychiatric diagnosis, functional status and co-morbidities (e.g., medical, substance abuse, cognitive), possibly based on the Four-quadrant Model of integration, a LOCUS score, a MORS score, or other option for describing functional status.

We would use an open access model and level of care model, based on a client's disabilities and functional status as related to mental illness.

5. Which services do you consider to be essential to a model of integrated care for duals?

Both physical and behavioral health prevention and early intervention services are essential. Additionally, ongoing care-coordination services for physical and behavioral health would be essential, including medical and behavioral prevention and early

intervention services, primary medical care, behavioral health screening, behavioral health services, substance abuse services and dementia care.

6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?

Information needs to be extended to all dually eligible beneficiaries. Some mechanisms for extending that information include outreaching to alternative sites, in addition to primary medical care offices. For example, outreach could be conducted through homeless shelters, Meals on Wheels, senior centers, and a direct mailing with all Social Security checks. All current Medicare and Medi-Cal funded agencies should be required to provide information to all patients. Providers need to be educated that beneficiaries are not only found in primary care offices.

7. What questions would you want a potential contractor to address in response to a Request for Proposals?

First and foremost: What patient specific reduction in medical necessity and functional impairment as quantified by standard and observable measures do you project as a result of these services?

What services are you going to integrate?

How will you incorporate behavioral health, including mental health, substance abuse and dementia care services?

How are you going to integrate all these services?

How much is this going to save?

How are you going to engage dually eligible beneficiaries in long-term supports and services?

8. Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries?

We recommend utilizing the same standards defined in the Rehabilitation Option standards, not the Medi-Cal standards.

For sensitivity regarding the needs of the dually eligible population, every provider should be required to be trained in geriatric behavioral and medical health needs, and resources available to meet those multifaceted needs.

With regard to accessibility, specific training should be required for providing services in the field, including providing home- and community-based services.

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

We would be able to subcontract, as per number 4, above.

Additionally, we could provide part of the required training described in number 8, above, specifically as related to providing services in the field, provision of mental health services, and dementia care services. We have experience in doing this type of training statewide.

10. What concerns would need to be addressed prior to implementation?

Gaining buy-in from beneficiaries, given the narrowing of freedom of choice for beneficiaries;

Ensuring that services will be able to be delivered to home-bound and frail, dually eligible beneficiaries.

Ensuring that services are accessible, without long waiting periods.

Being sure that care is provided with quality as its major focus, not just cost savings.

11. How should the success of these pilots be evaluated, and over what time frame?

Effectiveness should be evaluated using measures of individual patient's health and behavioral health, and cost savings related to health, particularly long-term care. It should be noted that with physical decline, especially applicable to the dually eligible population, maintenance/stabilization of functioning can reflect success.
Time frame: 2 years

12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

Utilize effective models already piloted in other states as guiding principle